"Who Are Our Support Networks?" A Qualitative Study of Informal Support for Carers

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ABSTRACT

There is little information about the types of social support and content of assistance for informal carers. This article aims to fill this knowledge gap by studying 37 informal carers in a region of the UK. It was found that adult children were the main source of support for older carers regardless of ethnic backgrounds, minority ethnic carers supported their husband to fulfill traditional caring duties by taking care of mother-in-law in the same household. Young carers received support mainly from uncles and aunts to look after sick parents while adult carers obtained information and peer support from the internet. Surprisingly, support from neighbors was limited. Additionally, social support for carers was undermined by the stigmatization of drug and alcohol misuse and mental illness. It is proposed that different types of online support services and appropriate educational programs need to be offered to carers to set up self-help groups and tackle stigmatization associated with health problems. It is suggested that future studies can use a large representative sample to give a comprehensive picture on the contents of informal support for different types of caregivers and the impact of social support on helping informal carers to fulfill their duties.

Keywords: Informal carers ; social support ; stigmatization ; online support ; community support network

Introduction

The number of older people in the world aged 60 and above is expected to increase from 962 million in 2017 to 2.1 billion in 2050 (United Nations, 2017). It is believed that instead of institutional care, supported independence, as well as home-based or community care are better options for older people (United Nations, 2008) so that they can maintain constant contact with family members, neighbors, and friends. Thus, informal carers must have more assistance to help them fulfill caring tasks (Plöthner et al., 2019).

Social support concerns "various forms of aid" that a person receives from social networks (Song, 2011, p. 479). A person's informal support network includes family members, friends, neighbors, and church members (Caplan, 1974) who can provide them with material and information benefits (Grewe, 2003). Emotional support, instrumental support, and informational support (Song, 2011) are three types of assistance that help carers fulfill caring tasks.

The positive impact of social support on wellbeing is well documented (Bakar et al., 2014; Casale et al., 2013; Cohen, 2004; Gleeson et al., 2016; House et al., 1988; Kaufman et al., 2010; Sandoval et al., 2019). It has also been shown that social support is conducive to promoting good health or as a buffer against stress (Cohen, 2004; House et al., 1988). However, so far as the authors are aware, there are limited studies on who are informal networks of carers and the type of support that they receive. Moreover, there is little information about the differences in social

support between minority ethnic carers and their white counterparts. Against this background, this article aims to enhance our understanding of the contents of social networks of informal cares and the types of support that they obtain. This article can be divided into four parts. Part one reviews studies on social support for carers; part two explains the study's research methodology; part three reports the key findings; and the final part discusses actions that may enhance the support networks of informal carers.

The impact of social support and unresolved research issues

Studies in various countries have confirmed the positive impact of social support on the wellbeing of both carers and care recipients. In Chile, researchers found high levels of social support contributed to low levels of depression of carers (Sandoval et al., 2019). There have been similar findings in America and Taiwan. Cannuscio et al.'s study (Cannuscio et al., 2004), based on 61,383 female Americans aged 46 to 71, found that informal caregivers with extensive social ties had fewer depressive symptoms than those without those ties. Gleeson et al. (2016) study indicated that social support and family resources mediated kinship caregivers' stress. Another study showed that social support could enhance caregivers' confidence, contributing to positive health outcomes of the cared-for people (Kelley et al., 2017). With a sample of 103 caregivers of persons with stroke or Alzheimer's disease, Huang et al. (2009) study showed that carers with good emotional support had fewer depressive symptoms than those without that support. Similarly, instrumental and emotional support was positively associated with the health of HIV-positive caregivers (Casale et al., 2013). In Malaysia, good social support was confirmed to have reduced carers' pressures. Nawi et al. (2017) reported that positive social support facilitated young adult Malaysian carers to fulfill caring duties toward parents or close relatives.

However, there are several unresolved issues concerning social support and carers. First, most social support literature involved quantitative studies in which psychologists used standard scales to measure the impact of assistance on caregivers. Both informal and formal support were included in some scales. Thus, their findings cannot clearly differentiate the contributions of formal and informal support networks. For example, the Family Support Scale was used to measure available assistance for families raising children. The scale includes both formal and informal networks, such as the family, friends, social groups, professional agencies, and service providers (Littlewood et al., 2012).

Second, the content and nature of social support studies for carers is still unclear. Most studies investigated the perception of social support of caregivers. For example, Kaufman et al. (2010) used the Interpersonal Support Evaluation List to assess African American and white caregivers' levels of informal support rather than the types of social networks. However, Casale et al. (2013) pointed out that "greater attention should be paid to specific dimensions of support, such as types and sources, as well as the processes through which support may be affecting health outcomes" (p. 1204). Hellermann (2006) and Morgan (1990) stated that it is important to "differentiate different types and levels of social support and resources" of a person (cited in Ryan et al., 2008, p. 674).[AQ2]

Third, there are a limited number of studies comparing the social support networks of white and minority ethnic carers. Social support for caregivers may vary because of differences in ethnic groups and migration history. According to Ryan et al. (2008), there is "insufficient attention" (p. 673) to migrants' access to social networks in a new environment. We should not simplify the "complexity and diversity" of social support among ethnic minorities (Ryan et al., 2008, p. 677). In short, this study aims to mitigate this lack of information by informing policy makers and health and social care practitioners of the extent of social support among carers, and advising them on which actions are necessary to support caregiving duties.

Research methodology

The data for this article was gathered from a qualitative study investigating the needs of "seldom heard carers" in a UK local authority. Seldom heard carers are social groups who encounter special difficulties in accessing mainstream services. The local council classified some groups to be seldom heard carers based on its service experiences and the research findings of other studies (Carers Trust, 2016; Tonkiss & Staite, 2012). The types of carers groups and the number of respondents are shown in the Table 1.[AQ3]

Table 1. Carers groups and their number.

Carer group	Number of carers	Percentage (%)
Black and Minority Ethnic (BME) groups	8	22
New migrants/asylum seekers	3	8
Substance misuse carers	5	14
Young carers	3	8
Mental health	5	14
Carers in rural/isolated areas	3	8
Gypsies and traveler communities	3	8
Armed forces veterans	3	8
Lesbian, gay, bisexual and trans-sexual (LGBT)	2	5
People who have acquired brain/head injury	2	5
Total	37	100

Source: Chan et al. (2017).

This study adopted a qualitative research method because it aimed to obtain concrete information on respondents' caregiving experiences, their perception of their duties and their interactions with social networks. Interviews help to uncover facts (Collis & Hussey, 2013), allowing researchers to gather respondents' thoughts and feelings (Saranta-kos, 2013) and therefore, semi-structured interviews were conducted with 37 informal carers from July to November 2016. Most respondents were referred by non-governmental organizations, which chose carers according to the local council's definition of seldom heard carers and after having secured their consent to participate in interviews. A small number of respondents were self-referred after learning of the project from the research team's promotional materials.

Regarding the main characteristics of the respondents, most of them were female (76%), 8% were young carers under 18 years old and one third of them were aged over 65 (35%) (Table 2). Most respondents were born in the UK (70%), one was from Germany and the remainder were from the Caribbean, Africa and Asia. Concerning their em-ployment status, most were home makers (38%), some were already retired (19%), while others were either working (24%) or studying (16%).

Table 2. The main characteristics of the respondents.

Main features	Respondents (N = 37)	Percentage (%)
Gender		
Male	9	24
Female	28	76
No response	1	3
Age		
Under 17	3	8
18–44	4	11
45–64	17	46
65–74	11	30
75 or above	2	5
Place of birth		
UK	26	70
India	2	5
West Germany	1	3
Caribbean	1	3
Jamaica	1	3

Main features	Respondents (N = 37)	Percentage (%)
Ethiopia	1	3
Nigeria	1	3
China	1	3
Hong Kong	1	3
Mongolia	1	3
Pakistan	1	3
Employment status		
Home-marker	14	38
Retired	7	19
Students	6	16
Employed	9	24
Unemployed	1	3

Most respondents were taking care of their husband, wife, or partner (40%), eight (22%) were looking after their son or daughter, seven (19%) were caring for their mother or father, and the remaining respondents were caregivers in other types of relationships (see Table 3).

Table 3. Care recipients' relationship with the caregivers.

Care recipient	Number (N)	Percentage (%)
Husband	9	24
Wife	3	8
Partner	3	8
Mother	6	16
Father	1	3
Son	7	19
Daughter	1	3
Granddaughter	1	3
Brother	2	5
Mother-in-law	2	5
Ex-partner	1	3
Friend	1	3
Total	37	100

In-depth interviews were used to explore the experiences of the respondents. Each was asked: "In the last 12 months, have you received support from family members/friends/neighbours when looking after the person?" They were further questioned about the support that was available from official and community organizations: "In the last 12 months what services have you used and/or what support have you received from the government, local council, NHS, or any other organization in relation to your role of looking after the person?" It should be noted that interviewers would ask follow up questions about the contents of support offered to the respondents.

Content analysis was adopted to examine the data of the interviews. A researcher first went through all transcripts and codes were put on contents related to the respondents' informal support networks and the types of assistance. After that, some codes were grouped together to form key themes. The principal investigator of the project re-checked the codes and the key themes. Some codes were changed and the key themes were revised following the discussions of the two researchers of the project. The final key themes included support from "immediate and exten-

ded family members", "friends", "neighbours", "non-governmental organizations", "assistance and resources from internet", and "drug dependency, mental illness and stigmatisation". The following sections will discuss the details of the main themes.

Key findings

The respondents were asked in the interviews whether they had received support from family members, friends, neighbors, and community organizations. The main findings are presented in the following subsections.

Support from immediate and extended family members

As many as 28 out of 37 carers (76%) obtained support from members of their immediate and extended families. First, married couples and cohabiting partners jointly cared for immediate family members and close relatives such as a son, granddaughter, brother or mother-in-law (R10, 11, 12, 19, 29). For example, Wendy (for privacy, names have been changed) and her husband worked together to take care of her 85-year-old mother-in-law with dementia (R11). Bernard and his wife looked after their 21-year-old granddaughter who used illicit drugs (R12). It was found that the caring role had shifted between wife and husband in the caregiving process. For example, Wendy replaced her husband to be a main carer after his mental health was affected by stress (R11). This decision gave a break for a member of a couple, maintaining their overall caregiving capacity.

For some ethnic groups, the wife has offered a high level of support to the husband to fulfill the traditional filial piety of an adult son to parents. Very often, a married couple will also live with needy parents to provide them with effective support. For example, Lily from China was taking care of her 75 year-old mother-in-law who suffered dementia and limited mobility (R2). Both Lily and Wendy were living with their mother-in-law while performing caregiving duties. Apart from these two cases, there were no white carers who were living with and taking care of a mother-in-law.

This study found that sons and daughters were the main source of support for older carers regardless of their culture and ethnic backgrounds (R5, 7, 12, 18, 19, 26, 34, 35, 37). For example, Deborah was a white older carer, who was looking after her husband with dementia (R18). Her son did repair work for her, and her two daughters regularly phoned and sent her text messages. Once, when Deborah was very ill, her daughters moved in to stay with her, helping to take care of her husband (R18). Similarity, older minority ethnic carers also relied heavily on children for help. For example, Victoria (R7), an Indian with a son living nearby, stated, "My son helps me a lot, I rely on him". Eighty-five-year-old Amelia (R5) from Jamaica also received support from two sons, one of whom fitted a new carpet for her house. Obviously, children were found to be the main source of support for older carers. They offer daily, practical, and emotional, support continually and extra immediate support for the respondents when they experience an emergency.

It should be noted that the main sources of support for young carers who looked after siblings were parents and grandparents. For young carers taking care of parents, they received assistance from grandparents, uncles, and aunts. Daniel (R22) commented that his elder brother helped to look after their mother, and caregiving was a "joint effort from both of us". Two uncles from the maternal family would also come to see if Daniel needed any assistance whenever his mother needed to visit the hospital. Another young carer, Chloe (R25), described her family as "very big and very close". Her uncles helped her a lot, who also would take her out for a break. Hannah regarded her grandparents as her "second parents" whose support was essential to her fulfilling caring duties for her mother (R23).

It should be noted that the availability of social support was affected by international and internal migration. For new immigrants, support would come primarily from new friends in the UK. For example, Alice (R10) was unable to get immediate assistance from family members in Nigeria. Thus, she sought assistance from friends. Similarly, moving to a new region will weaken carers' social ties. Rachel (R36) was a white carer who moved to a region in Nottinghamshire and lived there for about one year. She received support mainly from members of a carer group.

The findings of this study further show that the availability of support was affected by the nature of the problems of the care recipients. Mental illness and alcohol abuse were perceived as stigmatizing, so some carers were reluctant to tell relatives of their difficulties (R8, 16, 36). As Alan explained:

No. Because mental health is a stigmatizing illness, especially in the Indian culture. You cannot tell people about things, my mother is old, and she might think “oh terrible, terrible, terrible” so sad then it’d kill her. Other people, you know you just don’t tell them.

As a result, the relatives of carers knew little about their caregiving pressures.

The extent of support was also shaped by the nature of the relationship between the cared-for people and their relatives. Some people with alcohol dependency and poor mental health found it difficult to communicate effectively with others, which had disrupted their social ties (R14, 19, 30, 37). For example, Sophia (R14) was upset by her alcoholic partner’s poor relationship with his immediate and extended family members:

Um, he fell out with my daughter-in-law, my son’s partner. They weren’t married then, but he fell out with her and then I fell out with my brother, so you know it put me in a difficult situation. I didn’t know what to do.

The tense social relationships caused by drug and alcohol dependency, as well as mental illness, had weakened the carers’ relationship with immediate and extended family members, limiting their potential to offer support.

Support from friends and neighbors

Twelve carers received support from friends. Friends were especially necessary for minority ethnic carers who had recently arrived in the UK and for white carers who moved to live in a new region. Alice (R10) came from Nigeria and was taking care of her 4-year old son with complex health problems. Support from friends was critical to Alice to overcome tremendous pressures. For example, her friends looked after her children so that she could attend driving lessons. When she was upset, her friends would talk to her, and one friend even stayed with her overnight while she was in distress. Similarly, Rachel (R36) and her husband, who had a mental health problem, moved to live in a new region for only one year. They obtained support primarily from friends that they knew at an organization. In short, the respondents obtained practical and emotional support from new friends in new environments.

Some respondents obtained welfare information and assistance for mobility from friends. Bethany (R9) was a black asylum seeker and knew several friends through her church. These friends provided her with information about welfare and support services. As a result of her husband’s disability, Bethany and family members rarely traveled, and instead staying at home. With assistance from their friends, the couple could now visit their church, spending quality time there. The couple was able to meet people at least once a week, talking to them and thus receiving “emotional support that helped both of us” (R9).

Some carers got to know their friends at Christian churches, carers’ groups, and mutual aid organizations. Some of these support groups were set up by local councils and non-government organizations (NGOs) (R19, 21, 24, 25, 27, 28, 30). For example, Megan (R21) obtained a great deal of support from friends in a young carer group.

Four caregivers of this study obtained assistance from neighbors (R1, 7, 34, 37). A Chinese carer sought help from her neighbor whenever her elderly mother fell (R1). Victoria, an Indian carer, said that a neighbor chatted with her husband, which allowed her to take a short break (R7). Surprisingly, only one white carer (R34) received support from a neighbor. Margaret’s neighbor regularly emailed her to see if she needed any assistance (R34). Data from this study shows that the support from neighbors mainly consisted of one-off assistance or daily conversations. Limited support from neighbors may be partly caused by social stigmas associated with drug and alcohol dependency and mental illness, as some carers were reluctant to tell others about their loved ones’ problems.

Support from non-governmental organizations (NGOs)

There are different types of NGOs offering support for carers, including local charities, churches, minority community organizations, and support groups. The minority ethnic respondents of this study obtained support from their community organizations and churches (R1, 2 9). For example, Chinese church members occasionally visited Abigail (R1). Lily (R2) and her mother-in-law regularly used the services of a Chinese association. The church members of Bethany (R9) offered her welfare information, took her husband to the church, and gave her emotional support. In short, ethnic organizations played an important role in giving advice and offering activities for black and minority ethnic carers.

The white carers received assistance from mainstream NGOs, churches, and support groups (R14, 18, 19, 20, 21, 24, 25, 27, 28, 30). For example, Charlotte (R27) was very pleased with the support from a carers group organized by a local council. As she said, "a lot of us have got the same situation, we're all in the same boat, so you look round, and there are perhaps people worse off than what we are". It should be noted that a respondent had set up a support group to facilitate mutual help among carers with similar problems. Florence (R30), who led a self-help group for six years, pointed out, "All the people who come to my support group are people with ADHD (attention deficit hyperactivity disorder), and they come with a partner, friend, and it is an opportunity to discuss about the condition, and different people come out with solutions for a problem".

As mentioned previously, young carers were very glad to have friends from carers groups who gave them a lot of support (R21, 24, 25). For example, Megan (R21) obtained advice from friends of a support group on how to take care of her young brother:

Well I really rely on that young carers group and made loads of friends there. I do ask some of them, mostly people who care for their younger siblings because I can relate to them more rather than their mum because it's very different. I've asked questions like if they're acting violent, how do you deal with it?

Chloe (R25) even claimed that her friends from a carers group "have been with me through thick and thin". The findings of this study demonstrate that some carers accessed formal support by joining carers groups established by local councils or charities. Later, members of the carers' groups became friends and offered emotional support for each other.

Information and support from the internet

This study shows that more carers were searching for information and support from the internet (R8, 32, 33, 34, 35, 36, 37). According to Alan (R8), "I network quite a lot, so I talk to people basically, and there's the internet. I've got Uncle Google to help me". Samuel (R35) got information from the internet on how to be an effective carer. Rachel (R36) pointed out the importance of internet information for an organization of ex-servicemen and women:

They have the web pages for both the injured and the carers, so Band of Brothers for the injured and Band of Sisters for the carers. They both have the Facebook pages that are there to support each other. People put what they like on there, they can have a rant, or they can put something useful. And often on those pages, there are links that this might be useful for someone or this is happening, or there are free therapy sessions or massages if anyone wants them. So, there's a lot of information out there.

The internet information also helped Holly and her partner (R32) to recruit a part-time helper to perform a cleaning job and chop vegetables for prepping meals for a few hours a week. The respondents who used the internet were between 48 and 65 years old. This suggests that the internet has become one of the main sources of support for adult carers.

Discussion

The findings of this study show that the respondents had received assistance from various actors and organizations. The social ties of the carers were shaped by ethnicity, immigration, social stigma, and technology. This section will critically analyze the implications of the carers' informal support networks on health and social care practices.

Strengthening internet-based support for carers

This study found that a significant number of carers used the internet to search for information about the health condition of their loved ones, how to fulfill caring duties, and how to obtain services to meet daily needs. Several caregivers also used the internet to communicate with other carers who were facing alcohol and mental health issues. Some carers did not share their difficulties with others because of stigmatization. To some carers, searching for information on the internet allowed them to avoid face-to-face contact, which will be a comfortable means to them. In addition, using the internet will save time and money for carers who live in rural and isolated areas. Online support may be able to reduce the "feelings of loneliness" of informal carers (Dam et al., 2017, p. 2). After studying 61 carers of people with dementia who had participated in online support forum, McKechnie et al. (2014) found that the respondents had received a wide range of benefits and their relationship with the care recipients had improved.

Given the positive impact of internet support, health and social care agencies dealing with drug and mental health issues can provide more web-based information and services like traditional over-the-counter services. Information, such as the physical and psychological health of the cared-for people, as well as the knowledge and skills necessary for taking care of alcohol addicts and mentally ill patients, can be made available on the internet. Moreover, support services, such as instant feedback to carers' enquiries, online counseling, and web-based peer support groups, can be developed to meet increasing demand from service users in today's technological society. These services will be particularly helpful for carers whose caregiving is associated with stigmatization or who are living in relatively remote areas. However, when developing these services, social services agencies need to pay attention to privacy, confidentiality, security, and computer literacy education for some users (Dam et al., 2017). In short, online information, peer support, and professional help needs to be further developed in order address the demands of different carer groups.

Carers' social support and neighbors

The findings of this study have enhanced our understanding of the content of social support of carers in the UK. There are several features regarding the social ties of minority ethnic carers. First, minority ethnic carers in this study relied on support from their wife/husband and adult children (R1, 3, 5, 7, 11). Second, ethnic carers who were new immigrants relied on assistance from friends and ethnic minority community organizations.

White carers also sought assistance from immediate and extended family members, including wives/husbands/partners, parents, sons, daughters, brothers, sisters, grandchildren, uncles, and aunts~~, it~~. It should be noted that adult children were the primary source of support for carers of this study regardless their ethnic backgrounds.

The findings also illustrate that friends play a key role in supporting both minority and white caregivers. Carers who were immigrants obtained welfare information as well as emotional and instrumental support from new friends in the UK. Surprisingly, the data showed that neighbors play a relatively minor role in offering informal support. Only four respondents mentioned the assistance given by their neighbors. As neighbors are important for checking on the safety of older and sick carers and offering immediate support in emergencies, it is essential to establish a community support network to mobilize residents to assist carers. For example, an organization in Hong Kong launched a "care agent" project in which young people were recruited to regularly visit carers and offer their services (Yung, 2019). In the UK, the Side by Side Research Consortium (2017) had produced a toolkit to facilitate peer support among mental ill patients in the community. It believed that peer support can reduce their social isolation and help them to obtain effective strategies to manage feelings. Thus, similar projects could be further launched by health and social care professionals to involve local residents and also promote mutual support among carers in their communities.

As was illustrated in the last section, stigmatization discourages some carers from seeking assistance from close relatives and friends. Carers of drug addicts and mental health patients were reluctant to share their difficulties to others. Rachel (R36) complained of her relatives' failure to understand the mental state of her husband. Some ethnic minorities face a more serious barrier in this aspect. As Alan pointed out, Indian culture had prevented him from talking about his son's alcohol problem with his parents (R8). Therefore, social work and healthcare organizations can launch more public education programs to enhance people's understanding of mental health and alcohol issues. In particular, the educational programs need to target specific ethnic groups that traditionally hold a negative attitude toward mental illness and drug misuse.

Faith and community organizations

As mentioned by several respondents, Christian churches, minority ethnic organizations, and mainstream NGOs offered them great assistance. Minority organizations also provided much help for immigrant carers who had limited social ties in a new community. For example, Wendy (R11) is an Asian who made friends at her church and the people there had become an important source of emotional and practical support for her. As mentioned previously, Bethany (R9) and her disabled husband were helped by church friends with welfare information, emotional support, and mobility. Non-governmental organizations are "a source of information and support" for informal carers (Department of Health and Social Care, 2018, p. 25). However, the functions of black and minority ethnic organizations in the UK are constrained by "marginalisation, inadequate funding and lack of strategic representation" (Gregory, 2010, p. 1). Thus, several actions can be taken by local authorities to enhance their work with ethnic organizations, including the

delivery of culturally competent training to welfare officers, the recruitment of minority ethnic staff, and seeking their advice on carers' issues (The Institute for Research and Innovation in Social Services, 2010). In the UK, ongoing budget cuts by both central and local governments have badly hit many black and minority ethnic organizations (Williams, 2019). Therefore, mainstream welfare agencies need to actively work with minority ethnic organizations, giving them the required resources to promote carers' welfare information and offer support services. This form of partnership will minimize cultural and language barriers in delivering services for minority carers.

More support for carers groups

The findings revealed that many caregivers obtained support from carers groups. Some group members even became friends of the respondents, offering them valuable advice. Deborah (R18) was thankful for all the support and assistance that she and her husband received from a carer group. Without the dementia carer support group, she would not have been able to socialize with others or talk to peers who could understand her needs. Carers' groups were particularly useful for young caregivers as well as those whose caring duties were linked with stigmatizing health issues. The benefits of carers' support groups were reported in various studies. They offered carers opportunities to express their feelings, share ideas, receive emotional support and obtain information (Newbronner et al., 2013). The UK government also reported that carers valued "social activities and peer support" (Department of Health and Social Care, 2018, p. 25).

Ideally, there should be local support groups that cater to different social groups. This is particularly important for older people who may not be able to travel far away from their hometowns, like Holly (R32). She and her partner could not drive a long distance to access help from family members who did not live locally. Moreover, time slots or regular meetings of certain support groups did not satisfy the needs of some individuals because they also worked in either part- or full-time jobs. For example, Thomas (R31) was happy about the carer support group, but the meeting time clashed with his working hours. Moreover, only one minority ethnic carer in this study received support from a carers' group (R8). Thus, welfare agencies and local governments are advised to put more resources to enhance the work of carers support groups by offering more time slots for meetings and developing more support groups for minority ethnic carers. Moreover, appropriate training programs and support services can also be offered to carers who intend to set up self-help groups to facilitate peer support in their communities.

Conclusion

This article aims to enhance our understanding of the content of social support of carers based on a qualitative study in a UK region. The findings show that family members—in particular, sons and daughters—are the main source of support for older carers regardless of their ethnic origins. They offer various types of assistance to reduce the respondents' caring pressures. For young carers, extended family members offer them valuable support while their parents suffer a chronic illness. Friends from churches and community organizations give emotional support and welfare information to carers as well, with carers who are immigrants and from minority groups benefiting the most from this source of assistance.

However, the social ties of some carers are limited by social stigmas attached to drug and alcohol dependency as well as mental health problems. Therefore, health education is urgently needed to tackle the stigmatization of health problems by enhancing the public understanding of the needs of drug addicts, mental health patients and their caregivers. On the other hand, this study found that neighbors are the least source of support for carers. Thus, health and social care organizations may need to promote locally-based support among residents. The social ties of carers will be strengthened by addressing the above two issues.

As the respondents of this study were mainly referred by non-governmental organizations based on the criteria of seldom heard carers defined a commissioning local government, the sample of this study had a high percentage of ethnic minorities, 24.3%, compared to about 13% belonging to "a Black, Asian, Mixed or Other ethnic group" in the UK overall (UK Government, 2020). Thus, the findings cannot be generalized to all types of carers. Having said that, this study has illustrated the contents of social support networks of some seldom heard carers and their barriers to access some of them. We suggest that a much larger and therefore more representative sample be able to tell us the general conditions of social support of different types of carers.

Also, the research team of this study was commissioned to investigate several issues, including the needs of carers, their access to informal and formal support services and their experience in using a carer's assessment. As a result of

having to answer several issues in an interview, the respondents could only briefly describe the contents of social support. We propose that future studies can investigate more details on the content of assistance and their effectiveness on helping carers to fulfill their caring duties.

Moreover, we can have a better understanding of the role of neighbors in supporting carers if a similar study is conducted in countries with different cultural backgrounds. In short, based on the findings of this study, further research work can be done in order to enhance our knowledge of caregivers' informal support and its impact on their well-being.

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